STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K013	A. BUILDING _____ B. WING _____	C 04/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E86TH ST, ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS This visit was a home health Federal complaint investigation survey. Complaint #: IN00101445; Unsubstantiated: Lack of sufficent evidence. Survey date: April 27, 2012 Facility #: 003413 Medicaid #: 200434910 Surveyors: Susan E. Sparks, RN, PH Nurse Surveyor Valco Healthcare Services, Inc. is in compliance with the Condition of Participation 484.10 Patient Rights, 484.14: Organization, services, and Administration and 484.55 Comprehensive Assessment as it relates to this complaint. Quality Review: Joyce Elder, MSN, BSN, RN May 2, 2012	G 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.